Lambaria Eyecare Associates

Glasses Contacts Medical

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE - HIPAA

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice") I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my record on the date identified below.

I understand that Lambaria Eyecare Associates may use and disclose necessary personal health information (for example my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit Lambaria Eyecare Associates to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Lambaria Eyecare Associates (for example mailings of exam reminders or information about services/ products provided by Lambaria Eyecare Associates).

I can be assured that Lambaria Eyecare Associates does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that Lambaria Eyecare Associates may submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products I have received.

_____

_____

Patient Signature or Patient's Legal Representative Date

AUTHORIZATION TO BILL INSURANCE

Lambaria Eyecare Associates participates with many different insurance companies. For your convenience, we will complete insurance forms and bill your vision or medical insurance where applicable. Any copays or deductibles not met at the time your claim is processed or denial of a claim will be forwarded on to the patient or responsible party. Your signature below authorizes the release of medical information necessary to process the claim and will assign benefits to Lambaria Eyecare Associates

_____

_____

Patient Signature or Patient's Legal Representative Date